Australian STI Management Guidelines for Use in Primary Care

Adult sexual assault

Overview

- In the primary care setting sexual assault presentations may be from a historical or recent incident.
- Always ask the client whether they want to involve the local Police Service or Sexual Assault Response Team.
- The following guideline is to help the clinician provide safe and comprehensive care to a person who has been sexually assaulted and may or may not want to make a complaint to the police at the time of the consultation.
- These guidelines can be used before or after a forensic examination.
- Ensure that the client is offered the option of forensic evidence collection; availability of medical-forensic services and timeframes vary from state to state.
- Assess psychosocial wellbeing and need for further support at each visit.
- Anyone disclosing recent or past sexual assault should be offered crisis counselling. This can be provided by 1800 RESPECT.
- Medical notes including an account of the assault, injury documentation, sexually transmitted infection (STI) tests and their results may be subpoenaed. You may be called to give evidence in court; therefore, your notes need to be precise.

Testing advice

Testing and management for people who have been sexually assaulted is an ongoing process and advice varies depending on how recently the alleged assault occurred.

Time post assault	Management overview

Up to 72 hours	Assess the need for immediate care; first aid or injuries that need attention, especially head injury. Ensure that the patient is offered the option of forensic evidence collection. In most states this can occur without police involvement (In some states this will be up to 120 hours post assault). If the client **does want** a forensic examination, assess them for acute injuries that require immediate medical attention, and refer to the local Forensic Examination Service or Sexual Assault Response Team. Ask about strangulation – e.g. "Was any pressure put on your neck during the assault?" If the patient has experienced a non-fatal strangulation, they should be assessed and referred to an emergency care provider for further assessment and management if required. Human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) – if indicated, 30 days of antiretroviral medication is required (see ASHM national guidelines for assessment of risk and prescribing this medication.) A starter kit for HIV PEP is available from most emergency departments and sexual health services. Hepatitis B Virus (HBV) infection: check hepatitis B surface antibody, hepatitis B core antibody and hepatitis B surface antigen ; offer vaccination to anyone who is not immune and vulnerable to infection. Hepatitis B immunoglobulin (HBIg) if the assailant is known to be HBV Ag positive (if indicated, can be administered up to 14 days post assault). Emergency contraception (EC): undertake pregnancy risk assessment and offer most suitable and accessible method of emergency contraception.
72-120 hours	• Assess immediate safety and wellbeing including the need for psychosocial support. • Emergency contraception: undertake pregnancy risk assessment and offer most suitable and accessible method of emergency contraception. • Test for chlamydia and gonorrhoea from each orifice that had penile penetration. • Consider *Trichomonas vaginalis* testing if patient or the offender was from an at-risk community. • STI testing and screening are not required for digital penetration or mouth-to-vagina assault.
4 weeks	• Assess psychosocial wellbeing and need for further support. • STI screen if not done already. • Pregnancy test (urine HCG) and discuss ongoing contraception if indicated. • Administer next dose of hepatitis B vaccination if indicated.
6 weeks	• Assess psychosocial wellbeing and need for further support. • HIV blood test. • Post HIV PEP assessment if indicated (see ASHM Guidelines).
12 weeks	• Assess psychosocial wellbeing and need for further support. • HIV, syphilis, HBV blood test (if indicated). • Consider hepatitis C virus (HCV) blood tests if the client was assaulted with injectable drugs, or injected drugs voluntarily before the assault.

24 weeks	• Assess psychosocial wellbeing and need for further support • Final HBV vaccination if indicated.
Historical sexual assault or abuse – many weeks, months or years before presentation	• The patient may want to be fully assessed for STIs and Blood Borne Virus (BBV) infection. • They may want help contacting the police to make a complaint – in all states and territories of Australia there is no barrier to making a complaint due to elapsed time (Statute of Limitations). • They may want psychological support (recommend a counsellor with trauma expertise) or just someone to talk to and share how they are feeling or coping with their experiences (e.g. anniversary of the assault, their child is now the same age as when they were assaulted).

Follow-up

Use the above table as a guide for follow-up appointments as required.

Always ensure the patient continues to be safe psychologically, socially and physically.

Ensure all infections are treated, see the following guidelines for treatment advice

- Chlamydia
- Gonorrhoea
- Syphilis
- HIV
- Hepatitis B
- Hepatitis C
- Mycoplasma genitalium
- Trichomonas vaginalis

Auditable Outcomes

- 100% of people reporting sexual assault are offered psychosocial support at each visit.

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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